EXHIBIT 22

The 340B Drug Discount Program in Review:

How Abuse of the 340B Program is Hurting Patients

Over 15 Years *of* Making a Difference in Cancer Care

The 340B Drug Discount program exemplifies how good ideas, no matter how well-intended, can easily go bad if they fall into the wrong hands and are abused. Ultimately, abuse of the 340B program has begun to harm the very poor, uninsured, and underinsured patients it was meant to serve.

340B is a critically important program for Federal grantees, community and disease-specific health clinics, and the true safety-net hospitals that rely on the drug discounts it provides to treat America's most vulnerable patients. However, in recent years, the 340B program has been co-opted and grossly abused by some large hospital corporations. Today, nearly half the hospitals in the United States are in the 340B program, even though research has shown that most provide very little charity care.

Bad actors in the 340B program have realized that they can make substantial profits by buying deeply discounted cancer drugs, which are then reimbursed by Medicare and private insurers at full cost — providing hospitals with up to 100% profit margins on these expensive drugs. However, hospitals are under no obligation to use 340B savings to directly help patients or lower the cost of care for them. 340B hospitals don't even have to disclose how 340B profits are being used. 340B profits can be used to finance new hospital construction, fund CEO bonuses, and a host of other hospital interests that do not directly, or even indirectly, benefit the very needy patients that the 340B program was designed to serve.

Today, patients whom 340B was intended to help are often paradoxically harmed by the program, cut off from timely and high-quality care by hospitals seeking to make profits from it. This has been particularly acute for cancer patients who face quotas, wait lists, and significantly higher costs at 340B hospitals that prioritize fully-insured patients and the profits they bring.

Community oncology practices provide substantial amounts of charity care to poor, uninsured, and vulnerable patients despite not receiving the benefits of discounts, subsidies, tax exemptions, or non-profit statuses enjoyed by 340B hospitals. They are, however, unable to write off the costs of chemotherapy drugs purchased at full price. Referring eligible patients to 340B hospitals to receive discounted drugs is the very purpose of this program. Yet, as the stories in this compilation show, some 340B hospitals have introduced barriers that actually prevent patients from accessing the care they so desperately need.

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Oncologists and administrators at community oncology practices provided the Community Oncology Alliance (COA) with the real stories in this compilation as firsthand examples of the negative impact that bad actors in the 340B program are having on patients. The real stories in these pages provide just a small glimpse into how the program has gone off the rails, and is just a sampling of the problems being created by some greedy 340B hospitals. The stories are presented anonymously because some local physicians and practices have been punished for speaking out against 340B program abuses by hospitals.

Favoring the Rich Over the Poor

In March, a singer in her early 50s felt a mass in her breast. Uninsured, she went to get a mammogram on a mobile bus that travels the city offering free breast screenings to women. The mammography technicians noticed signs of abnormality and sent her to have a biopsy, which confirmed she had HER2 amplified breast cancer. However, when she went to the local hospital that receives 340B drug discounts for treating uninsured patients, she was turned away. And she was not the first.

Like many other cancer patients before and after, the singer was placed on a waiting list at the hospital and denied care. This was not because of an actual capacity issue, but because

the hospital has placed a cap on the number of uninsured patients it is willing to see each month — despite the fact that this particular hospital participates in 340B and receives millions of dollars in funding. In fact, $12 million alone of this money has been earmarked for treating breast and gynecological cancer patients like her.

After three months of waiting for the hospital to accept her, and the cancer meanwhile growing unchallenged, an acquaintance got her an appointment at the local community oncology clinic. She met with the head doctor there and finally began treatment, with the clinic advocating on her behalf to access free and low-cost chemo meds. "She was one of three similar pro-bono cases we took on last month alone," says her doctor. "However, what of those women out there who don't know we're here? Who just curl up in a corner and don't receive care, while there's the ticking time bomb of cancer working away inside them?"

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Another patient, a 26-year-old, felt a mass in her breast one morning. Despite the patient having insurance and being unable to afford the cost of a mammogram, the 340B hospital turned her away. She managed to find a local clinic that charges patients on a sliding scale and had a mammogram and an ultrasound performed. Finding an abnormality, the technicians there referred her to the community oncology clinic, where the oncologist confirmed that she had a risky and rapidly growing, but highly curable form of cancer, as well as the inheritable BRCA mutation. Time was of the essence. The clinic started her on chemotherapy, scheduled her for surgery, and ensured that she had fertility preservation. They also helped her complete the necessary paperwork to get on Medicaid. She had always qualified for the insurance; simply no one at the hospital had ever taken the time to escort her through the process.

Despite all this, these two patients were actually the fortunate cases.

According to the community oncology clinic, these women are a drop in the bucket; in fact, doctors there know of at least sixteen additional women currently waiting for treatment of their gynecological cancers at the local 340B hospital. Many of these patients have curable yet rapidly growing cancer, and the delay in their diagnosis and treatment, even by a few months, is easily handing each one a death sentence.

"Despite their tax-exempt status, and despite the fact that there is physician time and clinic space available, this 340B hospital has decided internally on a specific budget limit for treating indigent patients, which translates to a certain quota of patients for the month. Once they exceed that quota, they start turning patients away at the door. So instead of using their resources on the patients who actually need 340B drug discounts, the hospital can enjoy all the profits coming from 340B by treating more affluent patients," explains the doctor.

340B hospitals receive drug discounts that are meant to benefit indigent patients, but without any real requirements or oversight to ensure that this actually happens. Thus, we see situations in which a tax-exempt facility that has received 340B discounts, in addition to millions of dollars in funding — even targeted funding for breast and other specialized cancers — refuses to see patients because of their inability to pay.

You Need Chemo? Sorry — We Treat Only the Rich

A 50-year-old mother on Medicaid came to a community oncology clinic suffering from angiosarcoma of the gallbladder. This is a highly aggressive cancer with a very poor prognosis and the patient was badly in need of treatment, which included tests, a port, chemotherapy, and more.

The doctor said, "Let's admit you to the hospital and get you started on your treatment while your Medicaid goes through." The patient was admitted to the non-profit, 340B hospital on a Friday, yet on Monday, it discharged her, saying they could not provide treatment. Why? Because she needed chemotherapy, and the hospital only treated indigent patients with chemotherapy in the outpatient setting.

Recognizing the urgency of starting treatment, the doctor referred his patient to a for-profit hospital, knowing it would take her. "This patient got her insurance worked out over the next few months, and that 340B hospital would have ultimately been paid. However, they didn't want to take any chances, despite being one of the region's most profitable hospitals."

340B hospitals often argue that savings from the program are being used to support all operations across the hospital to offer patients increased access. That is one of the many reasons why they do not need to demonstrate that patients are directly benefiting from the program. However, stories of hospitals restricting or avoiding treating patients in need because of

the profit they can make from more affluent, insured patients abound — particularly in the inpatient setting, where space can be saved for more lucrative patients.

Our Way or the Highway

One community oncology clinic covers a large regional geographical area, in which there are two competing hospitals, both with 340B, with one serving a fairly rich and well-insured patient community. The community clinic was originally renting space from the hospital located in the affluent neighborhood. That hospital then acquired 340B status by becoming a child site of a separate location in their system.

One day, the hospital informed the community oncology clinic that there were so many cancer patients, they needed to provide additional care and would be hiring their own oncologist. The manager of the community clinic responded that they felt confident they could handle the entire cancer population and such changes were unnecessary. Nevertheless, the hospital opened its own infusion center and started providing chemotherapy, literally next door to the existing community oncology clinic.

This community oncology clinic never turns a patient away; they treat everyone regardless of their insurance situation. However, without the benefit of programs like 340B, they cannot afford to give away cancer drugs for free, so they will often start treatment while trying to get the patient financial assistance — from patient assistance foundations, pharmaceutical companies, etc.

Realizing a situation that could benefit patients in need, the community oncology clinic proposed an arrangement with the hospital: "We have patients with no insurance and in need of chemotherapy; you have 340B — designed exactly for this purpose — so we'll send our indigent patients to you for their outpatient chemotherapy." But when they tried to put this into practice, the hospital refused.

The community oncologists met with them, arguing, "But you are supposed to use this charity for indigent patients! How can a patient, in a community with a 340B hospital, not benefit from it?" The hospital answered that they would help the patient, but only if they took over all of their care. This happened time after time, until finally the community clinic stopped asking. Today, they send their indigent patients to the other 340B hospital. "It's a 45–60 minute drive for them, and while it compromises their care, the patients deal with it to stay with us as their oncologists," they explain.

One example of a patient affected by the hospital's policy was an elderly man with multiple disabilities who was diagnosed with a blood clot in his lung. He was prescribed an oral anticoagulant in combination with a series of daily injections that must be given until the oral drug begins to work. In effect, he needed a few small shots along with a simple blood test, to be done over the weekend to determine if the medicine was working. The local 340B hospital nevertheless refused to take him. The patient was reduced to tears. He would now need to find a family member or neighbor to give up the better part of their day and drive him each day to the other hospital — a 2-hour round trip plus waiting time. This, as opposed to the 20-minute outpatient procedure he would have had, and the ability to handle it without feeling he was inconveniencing someone else.

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Another patient with Stage III breast cancer had no insurance and no money, yet desperately needed chemotherapy to shrink the tumor before surgery. Her doctor tried to get her 340B drugs at the local hospital, explaining that she needed daily shots and blood work, and it would be very taxing for her to drive daily an hour and a half each way to the alternate hospital. As always, the hospital refused. So, the patient had to get in her car and drive 3 hours round trip every day for a 5 minute shot to boost her white blood count.

When hospitals begin making profit-centered policies rather than patient-centered ones, the situation becomes dire. Quite simply, the potential for profiting from 340B drugs has caused a shift in many hospitals' priorities, and poor patients are the ones to suffer.

We Don't Get Paid for Ambulance Transport

A 58-year-old indigent woman with Stage IV non-small cell lung cancer was admitted into the local 340B hospital, suffering from superior vena cava syndrome (obstruction of the vessels that carry circulating blood into the heart). The hospital refused treatment, immediately discharging her and referring her to the private oncology clinic down the street.

Despite the patient's critical condition, the 340B hospital even refused to transfer her by ambulance, citing the cost they would incur. Thus, an uninsured patient, in urgent need of radiation and chemotherapy, had no alternative but to walk out of the hospital, get in her car and drive to the community

oncology clinic, in danger at every moment of becoming hypoxic and coding. Upon reaching the community oncology clinic, the patient received immediate radiation, upon which her condition stabilized, breathing improved, and there was a decrease in her symptoms.

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According to a doctor at the community oncology clinic, this has been a familiar scenario over the last few years. Since the 340B hospital came under new ownership, it has been unwilling to accept indigent and uninsured patients. While the community oncology clinic provides free radiation treatments, they cannot afford to provide free chemotherapy drugs. The result is that, despite having a 340B hospital in their community, indigent patients have nowhere to turn for the medication they need. "340B pricing exists to help just such patients," says the clinic doctor, "but with the hospital so concerned about utilizing this program to increase its margins on privately insured patients, they fail to use the program as it was intended — to help the patients who truly need it."

When 340B hospitals start discharging patients in critical condition, refusing to treat or even transport them to another facility, it is clear that there is something very wrong with the system.

If You've Got the (Insurance) Money, We've Got the Time

A young woman went to the local 340B hospital one day to follow up on a suspicious lump she had found. Sure enough, they diagnosed her with breast cancer. As if that wasn't bad news enough, the hospital then told her that they did not take her insurance, and since they could not figure out her co-pay and co-insurance, she would have to leave the hospital — despite the fact that they have seven oncologists practicing there. They didn't even bother to refer her to a place that would treat her.

Fortunately, the woman learned of, and went to, the nearby community oncology clinic. There she was welcomed with open arms, and the staff patiently helped her to figure out all of the insurance paperwork to begin treatment. Today, she is in her third course of chemotherapy and doing great, but she's one of the lucky ones. According to the clinic's office manager, there are multiple stories, just like hers, many of whom never make it through the clinic's doors.

"The real damage is the blatant abuse of the 340B program," says the office manager. "What happens is the hospital system buys up a variety of medical practices, and then refers their best patients to those practices. In the case of this patient, she was not seen as worthy enough from an economic standpoint, so they simply turned her away. They don't want anyone on Medicaid or who is uninsured. But they love those who are fully insured."

Again and again, practices across the country are reporting that hospital systems with 340B discounts shut out the very patients the program was meant for — often without even trying to help. One of the most frustrating parts is that if they would simply dedicate some time to helping these patients, they would find that there is insurance money available to them, and thus to the hospital. But these hospitals don't feel it's worth the effort.

Send Us Your Profitable Patients

One community oncology clinic has been desperately fighting for its existence against a local 340B hospital system. This hospital is one of several oncology units located in wealthy, well-insured neighborhoods — all of which serve as satellite cancer centers of a single downtown hospital that has 340B certification due to the inner city's indigent population.

The 340B hospital located near the community oncology clinic decided to go aggressively after what it saw as profitable cancer patients. First, the hospital set up its own oncology department, and then went after the clinic's doctors, offering salaries well beyond market prices and successfully wooing three of them over. Next, the 340B hospital established a new policy that refused privileges to any of the clinic's doctors. Thus, whenever a clinic patient ends up in the hospital, their treating doctor is unable to see them. In the meantime, the hospital tries to convince the patient to switch over to the hospital's own oncology unit for their cancer care.

According to the clinic, the hospital system's original 340B downtown location doesn't even have its own outpatient infusion center. After diagnosing indigent patients with cancer, they are referred to one of the satellite centers in the suburbs. These patients must then either take a bus or find a ride out to the suburbs; or, as perhaps the hospital hopes they'll do, find themselves a different hospital system altogether.

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Oftentimes, multiple hospital locations gain access to 340B discounts thanks to a single eligible site that treats a high number of eligible patients. At that point, the 340B hospitals in affluent areas build up oncology wings for the rich, with little to no money being pumped back into the original location with patients that truly need it — and that it was meant to help in the first place.

Charging More Than Double for the Same Care

A retiree with neuroendocrine carcinoma has been under the care for several years of an oncologist at a community oncology clinic. As part of her treatment, she receives monthly injections.

A few years into her treatment, the patient received notice from her insurance provider that she would now have to go to the local hospital to receive the injections. Thus, now she must go first to the clinic to get the prescription, and then go to the hospital for the injections.

According to the insurance company, the change was meant to reduce expenses; however, the bills the patient has received tell a different story. Previously, the community oncology clinic was charging some $4,000 a month for the medication, $3,000 of which was paid for by Medicare. Now, for the same injections, the hospital is billing $9,500, out of which Medicare is paying $3,800.

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Despite the fact that the hospital is 340B certified and gets a substantial discount on its outpatient drugs, it is charging an exorbitantly higher price for them — nearly two and half times! It seems everyone is losing… except the hospital.

Another side effect of shifting patient care into 340B hospitals is the significant difference in costs that patients, payers, and taxpayers must bear. It is a well-documented fact that cancer care delivered in a hospital setting is much more expensive than the same exact care delivered in the community oncology setting.

About the Community Oncology Alliance

The Community Oncology Alliance (COA) is the only non-profit organization dedicated solely to preserving and protecting access to community cancer care, where the majority of Americans with cancer are treated. COA helps the nation's community cancer clinics navigate a challenging practice environment, improve the quality and value of cancer care, lead patient advocacy, and offer proactive solutions to policymakers. To learn more, visit www.CommunityOncology.org.